

South Carolina Workers' Compensation Commission
1612 Marion Street
Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5675



WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ SSN: _____ - _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

Date of Injury: _____

Preparer's Name: _____ Law Firm: _____

Employer's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Carrier: _____

Preparer's Phone #: (____) _____ - _____

Date of Accident: _____

Complete each information blank. Specify clearly when contentions are admitted in part and denied in part. The employer – insurance carrier in answer to the claim, respectfully shows:

1. It is **Admitted / Denied** that the employee sustained an injury on or about the date set forth in the application. The reasons for denial are:

2. It is **Admitted / Denied** that both the employer and employee were subject to the Workers' Compensation Act at the time in question. The reasons for denial are:

3. It is **Admitted / Denied** that the relationship of employer and employee existed at the time in question. The reasons for denial are:

4. It is **Admitted / Denied** that at the time in question the employee was performing services arising out of and in the course of employment. The reasons for denial are:

5. It is **Admitted / Denied** that notice of injury was given the employer. The reasons for denial are:

6. It is **Admitted / Denied** that the employee **Needs / Is Entitled to Additional** medical care as a result of injury. The reasons for denial are:

7. It is **Admitted / Denied** that the employee is entitled to temporary total disability for the period(s) of :

8. It is **Admitted / Denied** that the employee is permanently disabled. The reasons for denial are:

9. It is **Admitted / Denied** that the employee has a serious disfigurement.

10. It is contented that an average weekly wage of \$ _____ applies, according to attached accounting of employee's earnings as provided by law.

11. Further contentions or grounds of defense are:

I certify that I have served this document pursuant to R.67-212 by delivering a copy to:

Name: _____

Address: _____

on the _____ day of _____, _____ by ☐ first class mail ☐ personal service ☐ certified mail.

Preparer's Signature _____ Title _____ Date _____

Refer to R.67-205 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Judicial Department. Pursuant to R.67-606, a Form 20 must be filed with the Claims Department at least 30 days from the date of filing this form.